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Perceptions of the Clinical Nurse Educator Model Among Nurses and Midwives at Moi Teaching and Referral Hospital, Kenya

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Abstract

The Clinical Nurse Educator (CNE) model is essential in the evolving healthcare landscape for connecting theoretical knowledge with practical application, especially in resource-limited contexts such as Kenya. CNEs offer bedside education, facilitate professional development, and provide mentorship to nurses and midwives. Nonetheless, their effectiveness may be compromised by factors such as insufficient supervision, elevated patient loads, and personnel shortages, which can adversely impact the professional development of nursing staff. This study investigates the perceptions of nurses and midwives regarding the CNE model at Moi Teaching and Referral Hospital (MTRH), Kenya, a national referral institution serving a diverse and high-acuity patient population. Recognizing the CNE model as a strategic intervention for bridging the gap between theoretical instruction and clinical practice, the research explores its effectiveness in enhancing professional competence, mentorship, and patient care within a resource-constrained setting. Employing a sequential explanatory mixed-methods design, the study integrates quantitative data from structured questionnaires with qualitative insights from in-depth interviews and focus group discussions. A total of 274 nurses and midwives were sampled, alongside a census of 13 CNEs. Quantitative data were analyzed using SPSS version 28 with descriptive statistics, while thematic analysis was applied to qualitative data. Findings reveal that CNEs are highly valued for their interpersonal skills, emotional support, and bedside teaching, with competency ratings consistently exceeding 85% across five domains. Younger nurses rated CNEs more positively, reflecting generational differences in learning preferences. Nurses and midwives highlighted the practical and emotional benefits of the CNE model, whereas CNEs pointed to systemic challenges such as excessive workload, limited protected teaching time, and insufficient institutional support. The findings demonstrate the CNE role's capacity to strengthen clinical leadership, professional identity, and a culture of continuous

learning. To sustain and scale the model, structural reforms, increased staffing, dedicated teaching resources, and formal institutional backing are required. These insights provide guidance for policy makers and institutional leaders aiming to enhance clinical education frameworks in Kenya and similar contexts.

Keywords: Clinical Nurse Educator (CNE) model, professional development, mentorship in nursing, competency-based education

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Introduction

In an ever-evolving healthcare landscape, the role of a clinical nurse educator (CNE) is crucial for bridging the gap between theoretical knowledge and practical application, ultimately enhancing patient care. CNEs are essential in providing bedside education, professional development, and mentorship to nurses and midwives, ensuring they stay current with evidence-based practices and maintain competence (Heathcote & Green, 2021). This is particularly vital in resource-constrained settings like Kenya, where the quality of nursing and midwifery education directly impacts public health outcomes. Globally, nurses and midwives offer the bulk of health care. Qualified and competent nurses and midwives and health professionals are essential in the nursing field. All nurses world over are required to constantly improve on the quality of care and professional development. A number of countries have initiated CNEs who provide up to date bedside specialized development to fellow nurses and midwives (Nuryani et al., 2022).

Despite the clear importance of the CNE model, its effectiveness is often hindered by significant challenges. At Moi Teaching and Referral Hospital (MTRH), a major national and regional referral center, nurses and midwives are faced with a complex and demanding environment. Anecdotal evidence suggests that a lack of adequate supervision, insufficient time for teaching due to high patient load and staff shortages, and a disconnect between classroom theory and clinical practice negatively impact the professional development of nursing staff. These issues may lead to a perceived lack of support from educators, hindering the acquisition of new skills and the implementation of

best practices. While the existence of CNEs is recognized, there is a significant knowledge gap regarding how practicing nurses and midwives at MTRH actually perceive this model. Are they satisfied with the support they receive? Do they feel the CNE model effectively addresses their educational needs and improves their practice? Answering these questions is critical to identifying the specific barriers and facilitators to effective clinical education at the hospital.

The aim of clinical education in nursing and midwifery is to facilitate the transformation of theoretical knowledge into practical competence within real-world healthcare settings. It serves as a critical bridge between classroom instruction and professional practice, enabling learners to internalize, apply, and refine their understanding of core concepts such as patient care, ethical decision-making, and clinical reasoning (Jefford & Ebert, 2025). Clinical education is not merely about skill acquisition; it is a structured pedagogical process that cultivates reflective practitioners capable of navigating complex and dynamic clinical environments. At its core, clinical education seeks to develop clinical competence through supervised practice, mentorship, and experiential learning. Students are exposed to diverse patient scenarios that challenge them to integrate anatomical, pharmacological, and psychosocial knowledge into coherent care plans. This process fosters diagnostic acumen, procedural proficiency, and the ability to prioritize interventions based on patient needs and institutional protocols (Funa, 2024). Moreover, clinical education emphasizes the development of critical thinking and clinical judgment skills that are essential for safe, effective, and evidence-based practice. Through guided reflection, case analysis, and feedback from Clinical Nurse Educators, learners begin to understand not only what to do, but why certain decisions are made in specific contexts.

Clinical placements immerse students in the cultural, ethical, and operational dimensions of healthcare institutions, helping them internalize the values, norms, and responsibilities of the nursing profession (Nannen, 2022). They learn to communicate effectively with patients and multidisciplinary teams, advocate for patient welfare, and uphold standards of accountability and compassion. This socialization process is instrumental in shaping their professional identity and resilience, especially in high-pressure environments like tertiary referral hospitals. Ultimately, clinical education is a multidimensional academic endeavor that prepares nursing and midwifery students to become competent, ethical, and adaptive professionals. It integrates theory with practice, fosters critical thinking, facilitates professional identity formation, and aligns individual competencies with broader institutional goals. When effectively implemented, it contributes not only to individual learner outcomes but also to the performance and legitimacy of healthcare institutions (Grimes, 2020).

Many nurses and midwives perceive the CNE model as a valuable mechanism for bridging the gap between theory and practice. It offers structured mentorship, real-time feedback, and guided clinical exposure, which are especially critical in high-acuity environments. Participants in related studies have noted that when the model is consistently applied throughout the training period, it fosters greater confidence, clinical judgment, and professional identity among nursing students and junior staff (Benewaa et al., 2024). However, perceptions are not uniformly positive. Some nurses and midwives have expressed concerns about the adequacy of orientation, the

availability of trained Clinical Nurse Educators, and the institutional commitment to sustaining the model. For instance, a study done by Tsirigoti (2025) in highlighted that while educators and students understood the model's classroom application, they recommended comprehensive training prior to full-scale implementation. Others emphasized the need for collaborative relationships between educators and preceptors, suggesting that reflective practices and presence-based mentorship could improve mental well-being, care quality, and professional fulfillment. In addition, midwives and nurses have advocated for the expansion of the model beyond hospital settings into community health contexts, where mentorship and clinical accompaniment are equally vital. This reflects a broader understanding of the model's potential to influence not just individual competence but systemic health outcomes (Singh et al., 2024). Studies from Kenya such as Otunga et al. (2021) assessed nurse educators' supportive role and its effect on clinical learning of nursing students at Kenyatta National Hospital, Kenya. The study established that that while BScN students appreciated the opportunity to apply theory in practice, over half were dissatisfied with the use of evidence-based practice and lecturer involvement in clinical training. This suggests a disconnect between theoretical preparation and clinical mentorship, with students valuing experiential learning but questioning the depth of educator engagement. Similarly, Waswa (2024) highlighted that nurse educators were perceived as supportive when they were available and reachable; encouraging peer learning and supervising clinical teaching. However, it also noted a lack of formal guidelines from the Nursing Council of Kenya (NCK) regarding the clinical roles of undergraduate nurse educators. This regulatory ambiguity contributes to inconsistent expectations and execution of educator responsibilities across institutions.

This study aims to provide a comprehensive understanding of the perceptions of nurses and midwives at Moi Teaching and Referral Hospital concerning the clinical nurse educator model. By exploring their experiences, this research will provide evidence-based insights into the strengths and weaknesses of the current CNE system at MTRH. The findings will be instrumental in informing policy decisions and institutional strategies aimed at optimizing the CNE role. Specifically, this study's contribution will be to identify the core challenges that impede the effective implementation of the CNE model from the perspective of the end-users and to inform targeted interventions and training programs for both CNEs and clinical staff to improve professional development and patient care outcomes. By giving a voice to nurses and midwives, this research will directly contribute to the development of a more responsive and effective clinical education framework at MTRH and potentially serve as a model for other hospitals in Kenya and the broader African region.

Review of Literature and Theoretical Framework

Clinical Nurse Educator Model

Clinical nurse education is a major part of all undergraduate programs preparing nurses for competent professional practice. Several studies found that the clinical education model and setting are the most influential in the development of nursing competencies and professional socialization (Forman et al., 2020; Lewis et al., 2022; Lundell Rudberg et al., 2022)). Nurse educators play a critical role in the lifelong professional development of all nurses

and in maintaining and advancing nursing practice standards.

Clinical Nurse Educator (CNE) is a professional expert whose primary duty is to afford education to undergraduate, graduate, and postgraduate nursing students (Hamad et al., 2021). The role of a CNE is defined by Sayers et al. to supply education predominantly to nursing staff within a clinical setting. In developed countries, CNE was one of the career pathways for nurses in clinical settings. The World Health Organization stated that for becoming a nurse educator, a qualified nurse educator must be attained including: completed a recognized nursing education program both theoretical and practical component; holds a current license or registration or other forms of legal recognition to practice nursing; have a minimum of 2 years full-time clinical experience across the scope of practice within the last 5 years; have formal educational teaching preparation before or after employment as a nurse educator (Nuryani et al., 2022).

The scope of roles for the CNE including using creative and inventive strategies to promote a learning environment that supports flexible opportunities based on learners, enables professional development and competence by providing education and assessment of learners' priorities and clinical skills, develop and implement collegial networks maturely and effectively to produce positive learning outcomes for clinical staff; All the relevant stakeholders are held accountable by CNE, by showing openness to others, CNE gains confidence and trust in colleagues (Snow, 2020). CNE takes responsibility for training and service, and faith in action is apparent in the CNE as a role model, demonstrate the commitment to continuous improvement to maintain ethical practices, and is engaged in activities that show its commitment to the development of the best practices (Saadeh et al., 2024).

Nurses and Midwives Perception of the Clinical Nurse Educator Model

The Clinical Nurse Educator (CNE) Model is an innovative framework designed to strengthen the link between theoretical instruction and clinical practice in nursing education. At its core, the model positions experienced nurses (trained as educators) as key agents in mentoring, coaching, and evaluating clinical staff and students within healthcare institutions (Coventry & Russell, 2021). In Kenya, this model has gained traction, particularly at Moi Teaching and Referral Hospital (MTRH), where it was first implemented in 2013 as a pioneering initiative in a public hospital.

Academically, the CNE model is grounded in adult learning theory, experiential learning, and competency-based education. Adult learning theory, particularly as articulated by Knowles, posits that adult learners are self-directed, internally motivated, and bring prior experiences that shape their engagement with new knowledge (Hull, 2024). Within the CNE model, this theory informs the design of mentorship and instructional strategies that respect nurses and midwives as autonomous professionals. Clinical Nurse Educators, therefore, act not as didactic instructors but as facilitators who tailor learning to individual needs, encourage reflective practice, and foster empowerment (Bastable, 2021). This is especially relevant in the Kenyan context, where nurses often balance clinical duties with ongoing professional development, making flexible, learner-centered approaches essential. It emphasizes structured mentorship, simulation-based training, and continuous professional development.

At MTRH, Clinical Nurse Educators utilize the Assess, Diagnose, Plan, Implement, and Evaluate (ADPIE) framework to guide clinical instruction

and ensure that nurses are not only technically proficient but also capable of critical thinking and ethical decision-making. The model also incorporates preceptorship, where CNEs mentor newly recruited nurses, helping them transition into clinical roles with confidence and competence. This approach has been linked to improved patient outcomes, enhanced medication safety protocols, and the development of peer-reviewed standard operating procedures for high-risk interventions.

Methodology

Research Design

The research employed a sequential explanatory mixed-methods design, combining both quantitative and qualitative components. This approach provided a more comprehensive understanding of the CNE model by first establishing broad patterns and then exploring the underlying reasons and nuanced experiences (Othman et al., 2020). The process began with the collection of quantitative data through structured questionnaires to capture a wide range of information on perceptions. The findings from this initial phase were then used to inform the development of the qualitative data collection tools, specifically for the in-depth interviews (IDIs) and focused group discussions (FGDs). This iterative design ensured that the qualitative inquiry was directly relevant to the quantitative findings, allowing for a deeper exploration of the phenomenon under investigation. The study adopted both positivist and interpretivist research philosophies, acknowledging both the existence of an objective reality (measured quantitatively) and the importance of subjective experiences and social interpretations (explored qualitatively).

Study Area and Population

The study was conducted at Moi Teaching and Referral Hospital (MTRH) in Eldoret, Kenya. MTRH is a level six national referral hospital that provides a wide range of outpatient, inpatient, and specialized healthcare services to a population of approximately 24 million people in western Kenya and parts of neighboring countries. The hospital serves as a key training facility for various academic institutions, including Moi University College of Health Sciences. The study population consisted of all full-time nurses and midwives working at MTRH, totaling 954 individuals, of whom 13 were designated as Clinical Nurse Educators (CNEs).

Sampling and Data Collection

A census approach was used to include all 13 CNEs in the study, ensuring that the entire population of educators was represented. For the nurses and midwives working in the clinical areas, a total of 814 were eligible to participate. The study aimed for a sample size of 274, which was determined to be a representative sample for a population of this size. A simple random sampling procedure was employed, where each nurse and midwife was assigned a unique number within their respective ward or unit. Numbers were then randomly selected to ensure each individual had an equal chance of participating, thus minimizing selection bias and ensuring fairness and representation across all hospital sections.

Data collection utilized structured questionnaires, in-depth interviews (IDIs), and focused group discussions (FGDs). The questionnaires were self-administered by the nurses and midwives. The quantitative tool, based on the validated Nursing Clinical Teacher Effectiveness Inventory (NCTEI) by Knox in 1985, was used to rate CNEs on five domains: teaching ability, nursing competence, evaluation,

interpersonal relations, and personality. Qualitative data was collected through IDIs with CNEs and FGDs with both CNEs and nurses/midwives, with guides that were refined after the quantitative survey to probe for deeper insights.

Ethical clearance for the study was obtained from the Moi Teaching and Referral Hospital-Moi University Institutional Research and Ethics Committee (MTRH-MU IREC), and a research permit was issued by the National Commission for Science, Technology and Innovation (NACOSTI). Informed written consent was obtained from all participants prior to data collection. Confidentiality and privacy were maintained throughout the study by de-identifying all information and presenting data in an aggregate manner. All collected data were stored securely, with access restricted to the research team.

Data Analysis and Presentation

Quantitative data were analyzed using SPSS version 28. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize baseline characteristics and competency ratings. Univariate and multivariate analyses were performed to explore relationships between variables.

Qualitative data from the audio-recorded IDIs and FGDs were transcribed verbatim. Thematic content analysis was then performed to identify and categorize recurrent patterns, concepts, and themes related to the perceptions and experiences of the participants. Where applicable, direct quotes were used to illustrate and support the identified themes. The final findings were presented using tables, charts, graphs and a descriptive narrative.

Results

Baseline Characteristics

The study achieved an excellent response rate of 98.9% among the nurses and midwives. According to Table 1, the age profile of nurses and midwives was more diverse, spanning early-career to late-career professionals, whereas clinical nurse educators are concentrated in the 31–50 age range. The majority of nurses and midwives fall within the 31–50 age range (≈81%), with only 5.2% aged 20–30. The age of Clinical Nurse Educators is evenly split between 31–40 (46.2%) and 41–50 (53.8%). This suggests that educators are predominantly mid-career, likely with substantial clinical and academic experience. The broader age spread among nurses and midwives may result in heterogeneous expectations of educators where younger staff may seek more structured mentorship, and older staff may prioritize collaborative engagement or peer-level discourse. These generational differences could contribute to conflicting perceptions of educator relevance and effectiveness.

Gender, as another salient variable, reflects the broader feminization of nursing and midwifery in Kenya, with over three-quarters of both clinical staff and educators identifying as female. Nurses and Midwives were 77.9% female, and Clinical Nurse Educators were 76.9% female. The gender balance reflects broader trends in nursing and midwifery in Kenya, where women dominate frontline care roles. This demographic alignment may facilitate relational congruence in mentorship, fostering trust and interpersonal resonance between educators and mentees. However, it also invites inquiry into whether gendered expectations influence perceptions of educator authority, emotional labor, and pedagogical style. In contexts where caregiving is culturally feminized, female

educators may be expected to embody nurturing roles, which could complicate their reception when adopting assertive or evaluative functions within clinical supervision. Educational attainment presents a more complex dynamic. While most nurses and midwives hold diplomas or bachelor's degrees, clinical nurse educators are disproportionately represented at the master's level. The majority of the nurses and midwives hold diplomas (47.2%) or bachelor's degrees (33.6%), with only 4.4% at master's level. As for the clinical nurse educators, they were more highly qualified with 46.2% holding master's degrees and 53.8% with bachelor's degrees. This asymmetry in academic qualification may influence perceptions of credibility and pedagogical legitimacy. On one hand, educators with advanced degrees may be perceived as less attuned to the pragmatic realities of bedside care, particularly by diploma-trained staff whose professional identity is grounded in experiential competence. This tension between academic authority and clinical relatability is central to understanding the mixed or conflicting perceptions of the CNE model.

Table 1: Demographic characteristics

Nurses & Midwives		Clinical Nurse Educators	
Variables	**Values**	**Variables**	**Values**
Age		**Age**	
20-30	14 (5.2%)	31-40	6 (46.2%)
31-40	108 (39.9%)	41-50	7 (53.8%)
41-50	111 (41.0%)		
51-60	38 (14.0%)		
Gender		**Gender**	
Female	212 (77.9%)	Female	10 (76.9%)
Male	60 (22.1%)	Male	3 (23.1%)
Education Level		**Education Level**	
Masters	12 (4.4%)	Masters	6 (46.2%)
Bachelors	91 (33.6%)	Bachelors	7 (53.8%)
Higher diploma	40 (14.8%)		
Diploma	128 (47.2%)		

CNE Competencies (as Perceived by Nurses and Midwives)

The competency scores were calculated by adding all the items in each domain and expressing the total score as a percentage. The denominator was calculated considering missing values. For example, the Teaching Ability domain has 17 items on a 5-point Likert scale, meaning the maximum possible score (the denominator) is 17×5=85. In case one question was not answered, the denominator used was 80 to calculate that individual percentage score.

According to the findings presented in Table 2, nurses and midwives rated the Clinical Nurse Educators highly across all five competency domains, with mean scores consistently above 85%. Personality (89.7%) and Interpersonal Relations (89.6%) were rated as the highest competencies, followed by Nursing Competence (86.4%), Teaching Ability (86.0%), and Evaluation (85.0%). This finding highlights a crucial aspect of clinical education: the CNE's personal demeanor and relational skills are perceived as equally, if not more, important than their technical and

pedagogical expertise. The data suggests that for a CNE to be effective in a high-stress clinical environment, their ability to be approachable, empathetic, and non-judgmental is paramount to fostering a trusting learning relationship with staff.

Table 2: Clinical nurse educator competencies

Variables	Values
Teaching ability	
Mean (SD)	86.0 (14.9)
Median (IQR)	89 (80 – 98)
Range	20 – 100
Nursing competence	
Mean (SD)	86.4 (14.7)
Median (IQR)	89.5 (80 – 98)
Range	20 – 100
Evaluation	
Mean (SD)	85.0 (16.1)
Median (IQR)	90 (78 – 98)
Range	20 – 100
Interpersonal relation	
Mean (SD)	89.6 (14.6)
Median (IQR)	97 (80 – 100)
Range	20 – 100
Personality	
Mean (SD)	89.7 (13.9)
Median (IQR)	94 (83 – 100)
Range	20 – 100

Analysis of Competency Ratings

An analysis of the competency scores by demographic variables revealed several interesting patterns. There was no statistically significant association between gender and competency scores ($p>0.05$), indicating an equitable perception of CNE performance regardless of gender. However, younger nurses aged 20-30 years gave the highest ratings across all competencies, with scores generally decreasing as the age of the respondents increased. A statistically significant association was found between age and the ratings for teaching ability and nursing competencies ($p < 0.05$). This can be attributed to a generational difference in learning styles, where younger nurses may be more receptive to the interactive, feedback-rich, and technology-enhanced learning environments fostered by contemporary CNEs.

A weak but statistically significant negative correlation was found between years of experience at MTRH and the competency ratings ($r < 0.2$, $p < 0.05$). This suggests that as nurses' tenure at the hospital increased, their perception of CNE competencies slightly decreased. This trend may reflect a higher level of critical appraisal from more experienced staff, who may have historical expectations or different views on professional development than their younger counterparts.

CNEs Self-Assessment of Competence

Clinical Nurse Educators (CNEs) conducted a structured self-assessment using a standardized rating scale ranging from 1 (lowest competence) to 5 (highest

competence) across six domains of professional practice: Evidence-Based Practice, Pedagogical Competence, Administrative and Curriculum Management, Educational Technology, Networking and Social Competence, and Cultural Competence. Each domain comprised several sub-activities, against which the CNEs evaluated their own performance. For each domain, the mean score was computed and standardized to percentage equivalents. Table 3 presents the descriptive statistics, including mean scores, standard deviations (SD), and observed ranges.

Table 3: Self-Assessment Scores of CNE Competencies (n = 13)

Competencies	Mean (SD)	Range
Evidence-Based Practice	86.9 (9.9)	67.5 – 100
Pedagogical in Teaching & Guidance	93.3 (5.9)	78.2 – 100
Administrative & Curriculum	87.2 (8.3)	68.9 – 97.8
Educational Technology	91.1 (8.8)	76.0 – 100
Networking & Social	89.2 (8.9)	72.0 – 100
Cultural Competence	85.4 (13.1)	60.0 – 100
Overall Competence	89.3 (6.5)	76.7 – 95.7

Note. Ratings were on a 5-point Likert scale (1 = very low competence, 5 = very high competence)

The findings suggest that Pedagogical Competence (M = 93.3, SD = 5.9) and Educational Technology (M = 91.1, SD = 8.8) were the strongest domains, while Cultural Competence (M = 85.4, SD = 13.1) and Evidence-Based Practice (M = 86.9, SD = 9.9) reflected relatively lower, though still high, self-assessment scores. The overall competence score was 89.3% (SD = 6.5), indicating a consistently strong self-perception of professional capability across domains.

Qualitative Findings on CNE Competencies

Essential Competencies as Perceived by Nurses and Midwives

The qualitative data from focus group discussions (FGDs) with nurses and midwives provided rich detail on the competencies they believe a CNE should possess. Participants placed a strong emphasis on the CNE's knowledge and experience, with one noting that a CNE should have a minimum of "five to five and more years of experience in a given unit". This experience, particularly in a specialized area, was seen as a prerequisite for credibility and authority. The nurses and midwives overwhelmingly valued specialization, stating that a CNE "who is serving in surgery, medicine, neonatal unit, so having a specialization in that area is an added advantage". The qualitative findings reveal that their high rating of CNEs' teaching ability is a direct result of their preference for practical, hands-on learning. As one participant noted, "I observe that they also take up the practical part and they come and show us". This desire to be shown, rather than just told, how to perform a procedure underscores the fundamental need to bridge the theory-to-practice gap. The qualitative data further affirmed the CNE's role as a go-to clinical authority. Participants noted that they view CNEs as clinical leaders and their first point of contact for solutions to complex challenges.

Competencies Developed In-Service

In-depth interviews and focus group discussions with the CNEs

themselves revealed that their role is a personally and professionally transformative journey, actively cultivating a new set of competencies. CNEs reported a shift in their teaching philosophy, realizing that "teaching does not always equate to learning" and consequently adopting innovative strategies like simulation-based teaching to demonstrate procedures effectively. They also highlighted significant growth in leadership, stating that as a CNE, their colleagues "want you to be in the lead in case they have an issue" and that they are the person colleagues call "even if it's at night" when they face a challenging situation.

The CNE role also fostered growth in other vital areas. One CNE noted, "I have gained experience in research" since becoming a CNE, while another explained the development of critical thinking skills, stating, "you need to think critically... they are seeing you as a person who has solutions". The role also taught them patience, as they learned not to make assumptions about the knowledge level of their colleagues, even if they had the same training. The CNE model, therefore, functions as an on-the-job leadership development program, organically creating a new cadre of leaders and mentors who possess a broader skill set than their initial clinical expertise.

Comparative Analysis of Perceptions (Qualitative vs. Quantitative)

The integration of the quantitative and qualitative findings reveals a significant degree of convergence but also a subtle difference in focus. Both nurses and CNEs strongly agree on the importance of core competencies such as knowledge, specialization, leadership, and mentorship. The quantitative findings show that nurses highly rate CNEs across all five domains, with a particular emphasis on personality and interpersonal relations. The qualitative data illuminates the meaning behind these high ratings, revealing that the "personality" and "interpersonal relations" that nurses value are manifested in the CNE's ability to be approachable, patient, and non-judgmental, which creates a psychological safe space for learning. The qualitative data also shows that nurses and midwives prioritize tangible skills, such as knowledge, specialization, and hands-on teaching, while CNEs emphasize more cognitive and facilitative competencies that they have developed, such as problem-solving, public speaking, and active listening. This indicates that CNEs are consciously developing a broader skill set to navigate a role that requires them to be more than just experts in their field.

Perception of the CNE Model

Nurses' and Midwives' Perspectives

Qualitative data from nurses and midwives provided rich detail on their positive perception of the Clinical Nurse Educator (CNE) model, affirming its value in their professional lives. Participants emphasized that CNEs must possess deep, current knowledge, particularly aligned with the specific units they serve (e.g., ICU or paediatrics). A high percentage of nurses surveyed (79%) agreed that CNEs should be highly specialized, as this lends credibility and enhances engagement. There was a strong preference for practical, hands-on teaching, with 82% of respondents favouring bedside or simulation-based learning over traditional lectures. Nurses and midwives expressed a desire to be shown how to perform a procedure rather than just being told how to do it.

A majority of nurses (85%) reported that CNE mentorship made them feel more confident and safer in their clinical practice. CNEs were highly valued for their emotional and professional

support, acting as approachable, non-judgmental role models who guided new staff during onboarding and emotionally demanding cases. Nurses viewed CNEs as clinical leaders and their first point of contact for clarification or support during high-pressure scenarios, a role affirmed by over 70% of nurses. Participants highlighted the importance of CNEs being patient and non-judgmental, with 76% agreeing that emotional support is as important as technical teaching.

CNEs' Self-Perception and Experiences

Clinical Nurse Educators (CNEs) viewed their roles as a personally and professionally transformative journey, acknowledging significant growth in their own competencies. CNEs reported a shift in their teaching philosophy, adopting innovative strategies like simulations and interactive demonstrations, with 83% using such methods at least once a week. The CNEs also highly rated their own competence in educational technology (91.1%), having rapidly upskilled to use tools like PowerPoint and WhatsApp for teaching and communication. The respondents described their role as requiring the continuous development of leadership skills, including decision-making and crisis response, with a majority of CNEs (88%) feeling they were seen as clinical leaders in their units. CNEs highlighted a range of competencies developed on the job, including research, public speaking, and critical thinking, noting they had to learn to "analyze, interpret, [and] make judgments" across diverse specialties.

Despite the positive experiences, CNEs consistently cited systemic challenges. All CNEs cited excessive workload and resource constraints as major impediments. A significant portion (83%) acknowledged being routinely pulled into clinical shifts, disrupting their planned teaching activities and creating a "dual-role tension" that diminished the perceived legitimacy of their educational role. The lack of protected teaching time and dedicated physical spaces also emerged as a significant barrier.

Comparative Analysis of Perceptions

The findings reveal a significant degree of convergence between the perceptions of nurses/midwives and the CNEs, highlighting a shared understanding of the model's core function and value. Both groups strongly agreed on the importance of key competencies such as knowledge, specialization, leadership, and mentorship. This mutual recognition demonstrates that the CNE model is fulfilling its fundamental purpose of bridging the theory-practice gap through expert mentorship and guidance.

However, the analysis also reveals a subtle but important divergence in focus. While nurses and midwives are primarily concerned with the immediate, tangible benefits of the CNE model that is the hands-on teaching, the emotional support, and the on-the-spot clinical guidance CNEs themselves are acutely aware of the systemic and institutional barriers that underpin their work. For instance, CNEs rated their own competence lower in areas such as administrative and curriculum management, as well as cultural competence. The qualitative data further illustrates this, showing that nurses and midwives prioritize tangible skills, whereas CNEs emphasize more cognitive and facilitative competencies such as problem-solving, public speaking, and active listening.

Discussion

Perceptions of CNE Competencies

The exceptionally high competency ratings of the Clinical Nurse Educators across all domains, with a particular emphasis on personality and

interpersonal relations, provide critical insight into the factors that drive effective clinical education. The data indicates that the success of the CNE model is not solely dependent on the educators' technical knowledge but is strongly mediated by their ability to form trusting, empathetic, and respectful relationships with their colleagues.

This finding is consistent with broader literature on nursing mentorship, which consistently links soft skills such as communication, empathy, and approachability to positive learning outcomes, increased learner confidence, and reduced anxiety in clinical practice. For example, a recent qualitative study by Agyare et al. (2025) on student-nurse educator interactions across African institutions found that the quality of relationships especially trust, empathy, and respect significantly influenced learning outcomes, professional identity formation, and student engagement.

The CNE's role as a trusted mentor who can provide non-judgmental feedback and emotional support is particularly vital in a high-pressure clinical environment. This positive perception acts as a powerful enabler, encouraging nurses and midwives to actively seek out CNEs for guidance and to be more receptive to their teaching. This validates the importance of investing in the relational and emotional intelligence skills of nurse educators, as these attributes directly facilitate knowledge transfer and help to create a psychologically safe learning culture. The emphasis on emotional support (76% agreement) aligns with findings from studies like Gilbert et al. (2022) on preceptorship among Nurses in Clinical Teaching at Tenwek Hospital and Wachira et al. (2021) on reflective learning, which highlighted that feeling "heard and supported" is essential for confidence and clinical resilience among nursing staff.

Perceptions of the CNE Model

The study's findings reveal a multi-layered understanding of the CNE model as a dynamic and transformative framework.

The Transformative Nature of the CNE Role

From the perspective of the educators, the CNE role is more than just a job; it is a professional identity that fosters a new set of competencies. The data shows that CNEs are not simply applying existing knowledge but are actively developing new skills on the job, including leadership, research, and innovative teaching methods. This professional growth beyond their initial clinical expertise enables them to act as both educators and change agents. By leading interdisciplinary learning sessions and embedding evidence-based practices, CNEs are creating a ripple effect that extends beyond individual learning and influences the entire institutional culture of clinical governance and quality improvement.

Poindexter (2022) echoes the findings of this study when he notes that nurse educators are pivotal in transforming outdated educational models and shifting cultural norms within healthcare institutions. It argues that academic change agents are essential for integrating social determinants of health, telehealth, and community-based care into nursing education demonstrating how CNEs influence broader systems, not just individual learners. This indicates that the CNE model has the potential to cultivate a new cadre of nurse leaders, which is a strategic imperative for health systems in resource-constrained settings. On the contrary, some studies have reported conflicting results. For instance, notes Coffey and White (2019) that while many CNEs possess strong relational skills, others may lack formal training in educational theory or

mentorship. This can lead to inconsistent student experiences, especially in settings where clinical demands overshadow pedagogical priorities.

Bridging the Generational and Experiential Gap

The observation that younger nurses rated CNE competencies more highly than their older counterparts highlights a significant generational dynamic. Younger nurses, who have grown up with a greater emphasis on interactive learning, consistent feedback, and digital tools, are likely to find the contemporary CNE model more aligned with their educational preferences. This finding lends support the findings of a study by Macalindin et al. (2024) who note that younger nurses were more responsive to digital training interventions and showed higher uptake of digital documentation tools, suggesting alignment with tech-integrated CNE models. Conversely, older, more experienced nurses may have different expectations or may be more resistant to a structured educational model that interrupts established routines. This difference in perception suggests that CNEs must be adaptable in their teaching strategies, tailoring their approach not only to the learning styles of individuals but also to the experience levels of different cohorts. By doing so, they can ensure the model remains relevant and beneficial to the entire nursing workforce. While younger nurses often embrace digital tools, some studies such as Issenberg and Scalese (2008) caution against overreliance. For instance, excessive screen-based learning can lead to cognitive overload and reduced retention, especially when not balanced with hands-on clinical mentorship.

The Emotional and Psychological Impact

A critical finding from the qualitative data is the profound emotional and psychological impact of the CNE model on nurses and midwives. The mentorship and support provided by CNEs were directly linked to building professional confidence and reducing anxiety, especially among new staff. Lending support to this finding, a mixed-method study by Coventry and Russell (2021) conducted in Australia found that CNEs played a pivotal role in promoting competent and confident nurses through relational and visible leadership. Newly qualified nurses in graduate programs reported that CNEs helped them transition successfully into practice by fostering a supportive learning environment. The study emphasized that CNEs didn't need formal managerial roles to influence outcomes. The feeling of being "heard, understood, and supported" by an educator is a powerful motivator that can contribute significantly to staff retention and morale. This aspect of the model's success is a critical differentiator, as it addresses a major challenge in nursing, particularly in low- and middle-income countries, where burnout and staff turnover are major issues.

A study by AbdELhay et al. (2025) from Mansoura University Hospital in Egypt found that transformational leadership characterized by empathy, support, and active listening was a significant predictor of nurse retention. Nurses who felt emotionally supported and valued were more likely to stay, even in resource-constrained environments. The CNE model, therefore, serves not only as a tool for skill enhancement but also as a vital support system that fosters a positive and resilient professional environment. This lends supports lends support to the findings by Ahn and Jeong (2025) which found out that the CNEs' mentoring feedback focused on encouraging new nurses to maintain a positive attitude, inspiring their personal and professional growth, and offering

empathy and encouragement to help them cope with burdens and stress.

Conclusion

The CNE model at MTRH has been successfully implemented and is highly valued by both clinical educators and frontline nursing staff. The findings affirm that for a CNE to succeed in a high-stress clinical environment, personality and interpersonal relations are perceived as equally, if not more, important than technical expertise, as evidenced by the highest mean competency scores in these domains The results demonstrate a core alignment in the perceived value of the CNE model, with nurses, midwives, and CNEs agreeing on the essential role of specialized knowledge, leadership, and mentorship. Nurses and midwives overwhelmingly prioritize hands-on teaching and the CNE's role as a non-judgmental clinical authority, leading to tangible professional benefits. However, the study also highlights a critical structural challenge: the dual-role tension and lack of institutional support. While CNEs are successfully developing essential leadership and pedagogical competencies on the job, 83% cited being routinely pulled into clinical shifts due to excessive workload. This structural strain suggests that while the CNEs are effectively executing their role at the frontline level, the lack of protected teaching time and dedicated resources threatens the long-term sustainability and legitimacy of the model. The CNE model successfully creates a psychologically safe learning culture driven by the educators' soft skills, but its full potential is limited by systemic constraints.

Recommendations

The following recommendations are derived from the study's findings to enhance the effectiveness, sustainability, and institutionalization of the CNE model. They are directed at the relevant authorities: Moi Teaching and Referral Hospital (MTRH) Management, the Nursing Council of Kenya (NCK), and the Ministry of Health (MoH).

The core threat to the CNE model's sustainability is the "dual-role tension" caused by excessive clinical workload, as 83% of CNEs reported being routinely pulled from teaching to fill clinical gaps. MTRH Management must formally designate and protect CNEs' time for educational activities, allocating dedicated teaching spaces away from the bedside. Concurrently, the NCK and MoH should develop clear formal guidelines and a career structure for the CNE role, specifying qualifications (e.g., Master's level) and scope of practice. This action is essential to address role variability, elevate the CNE's professional legitimacy, and protect the educational function that nurses rely on.

Since CNE success is highly mediated by Personality and Interpersonal Relations (the highest-rated competencies), MTRH Management must prioritize continuous professional development (CPD) that focuses on soft skills. This includes training in non-judgmental feedback, empathetic communication, and active listening to reinforce the CNE's critical role in creating a psychologically safe learning environment for staff. Furthermore, CNE training must address generational differences in learning: CNEs need to be adaptable, utilizing interactive, technology-enhanced methods for younger staff while employing collaborative, peer-level strategies for older, more experienced nurses to ensure the model remains relevant to the entire workforce.

To ensure the model's scalability and long-term viability, underlying systemic issues must be addressed. The MoH and MTRH Management should increase nurse staffing levels to alleviate the workload pressures that currently

force CNEs to abandon their educational duties. MTRH Management should also formally integrate the CNE role into hospital governance and quality improvement frameworks. This elevates CNEs to the status of change agents, leveraging their expertise to shape institutional norms, embed evidence-based practices, and drive systemic advancement in clinical governance, thereby maximizing their influence beyond individual learning encounters.

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